



**Maine Department of Health and Human Services
HIV/AIDS Drug Assistance Program**

Section 1: About You

Name: (Please Print)			Social Security Number	
<div style="display: flex; justify-content: space-between;"><div>(Last) _____</div><div>(First) _____</div><div>(Middle Initial) _____</div></div>			_____ - _____ - _____	
Birth Date ____/____/_____ Mailing Address: _____ City: _____ State: _____ Zip: _____		Are you a Maine Resident?		Race: (Select all that apply) <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> Pacific Islander/ Native Hawaiian <input type="checkbox"/> Native American <input type="checkbox"/> Other _____
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Gender:		Ethnicity: (Please select one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other _____		

Daytime phone: (____) _____ May we leave a message at this number? ☐ Yes ☐ No

Nighttime phone: (____) _____ May we leave a message at this number? ☐ Yes ☐ No

Section 2: Your Income and Family Size

Family Size: _____ (You, spouse &/or those you support)	Total (pre-tax) <u>monthly</u> income is: \$ _____
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Please list your income for each month:

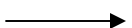
Salaries/Wages (Gross) \$ _____	Other (list) \$ _____
SSI (Blue Check) \$ _____	Other (list) \$ _____
SSDI (Gold Check) \$ _____	Other (list) \$ _____
Unemployment \$ _____	Other (list) \$ _____

Section 3: Your Health Insurance

1. Do you have MaineCare/Medicaid? ☐ Yes ☐ No MaineCare #: _____
If No: Have you applied for MaineCare? ☐ Yes ☐ No Date: _____

2. Do you have Medicare? ☐ Yes ☐ No Medicare #: _____
Do you have a Part D drug plan? ☐ Yes ☐ No
If Yes: Plan Name _____ Policy Number? _____

3. Do you have Private Insurance or HMO? ☐ Yes ☐ No or COBRA Insurance? ☐ Yes ☐ No
If Yes: Plan Name _____ Policy Number? _____



Section 4: Your Care Team

Doctor/Nurse Practitioner's Name

(_____)_____

Phone Number

HIV Case Manager's Name

(_____)_____

Phone Number

Other Support (who?)

(_____)_____

Phone Number

Other Support (who?)

(_____)_____

Phone Number

Section 5: Your Medical Information

Fill This Out With Your Doctor or Nurse Practitioner or Case Manager

HIV Status:

Latest Test Results (Please update with recent labs):

- ☐ Client has HIV (but not AIDS)
☐ HIV +, AIDS Status unknown
☐ CDC Defined AIDS

Test Date: _____ Absolute CD4 number: _____

Test Date: _____ Viral Load: _____

Provider First Name

Last Name

MD/DO/NP/PA/LCSW

(_____)_____

Phone Number

Address: Street

City

State

Zip

Signature

_____/_____/_____
Date

Section 6: Your Signature

By signing below, I certify that all information is true and complete.

Your Signature

Today's Date

Please mail this Application with the Release of Information to:

Lynn Berry - Maine CDC
286 Water Street, 9th Floor Key Plaza
11 State House Station
Augusta, ME 04333-0011

Phone for Assistance: 287-2899
Fax: 287-3498

For DHHS Use Only:

Date Authorized: _____

Date Application Received: _____

Authorizing Signature: _____